Public Employees Benefits Board (PEBB)

# 2007 Extension of Coverage Election

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- Make checks payable to the Washington State Treasurer.

| **Employee/Retiree Information ONLY** | Employee/retiree name | |
|---|---|---|
| | Employee/retiree social security number | Date employer or retiree coverage ended (mm/dd/yyyy) |

***I/we elect extension of coverage as indicated below:***

## Section 1: SUBSCRIBER INFORMATION

| Social security number | Sex ❑ M ❑ F | Last name | First name | Middle initial |
|---|---|---|---|---|
| | | | | |

Address _____ Apt./unit number _____

| City | State | ZIP Code | County of residence |
|---|---|---|---|
| | | | |

| Date of birth (mm/dd/yyyy) | Work phone number (including area code) ( ) | Home phone number (including area code) ( ) |
|---|---|---|
| | | |

The medical plans marked with an asterisk (*) in Section 3 assign a physician or clinic code to their providers and require you to choose a primary care provider. Contact your plan for code.

Physician or clinic code ➡

**Select coverage you wish to continue:** ❑ Medical/Dental ❑ Medical only ❑ Dental only

❑ **Cancel all coverage** **Reason** _____ **Date of event** _____

**Are you covered by another group medical or dental plan?** ❑ Yes ❑ No Effective date _____

**Are you disabled under Title II (OASDI) of the Social Security Act?** ❑ Yes ❑ No Effective date _____

**Are you disabled under Title XVI (SSI) of the Social Security Act?** ❑ Yes ❑ No Effective date _____

**If yes**, **attach a copy** of your Social Security Disability Award letter.

**Are you enrolled in Part(s) A and/or B of Medicare?*** Part A (hospital) ❑ Yes ❑ No Effective date _____

Part B (medical) ❑ Yes ❑ No Effective date _____

***Note:** If you are enrolled in Medicare Part(s) A and/or B, **attach a copy** of your Medicare card(s) along with this form.

## Section 2: FAMILY MEMBER INFORMATION

*List **only** eligible family members.*

| **A** | Relationship to subscriber | Social security number | Physician or clinic code | ❑ Disabled? ❑ Student? *Check only if age 20 or older.* | Sex ❑ M ❑ F |
|---|---|---|---|---|---|
| | | | | | |

| Last name | First name | Middle initial | Date of birth (mm/dd/yyyy) |
|---|---|---|---|
| | | | |

| Address (if different from subscriber) | City | State | ZIP Code |
|---|---|---|---|
| | | | |

**Select coverage you wish to continue:** ❑ Medical/Dental ❑ Medical only ❑ Dental only

Dependents of a retiree may choose medical/dental or medical only coverage.

❑ **Cancel all coverage** **Reason** _____ **Date of event** _____

**Are you covered by another group medical or dental plan?** ❑ Yes ❑ No Effective date _____

**Are you disabled under Title II (OASDI) of the Social Security Act?** ❑ Yes ❑ No Effective date _____

**Are you disabled under Title XVI (SSI) of the Social Security Act?** ❑ Yes ❑ No Effective date _____

**If yes**, **attach a copy** of your Social Security Disability Award letter.

**Are you enrolled in Part(s) A and/or B of Medicare?*** Part A (hospital) ❑ Yes ❑ No Effective date _____

Part B (medical) ❑ Yes ❑ No Effective date _____

***Note:** If you are enrolled in Medicare Part(s) A and/or B, **attach a copy** of your Medicare card(s) along with this form.

## Section 2: FAMILY MEMBER INFORMATION

***Use additional forms for more members.***
*List **only** eligible family members.*

**B**

| Relationship to subscriber | Social security number | Physician or clinic code | ❑ Disabled? ❑ Student? *Check only if age 20 or* | Sex ❑ M ❑ F |
|---|---|---|---|---|
| | | | | |

| Last name | First name | Middle initial | Date of birth (mm/dd/yyyy) |
|---|---|---|---|
| | | | |

| Address (if different from subscriber) | City | State | ZIP Code |
|---|---|---|---|
| | | | |

**Select coverage you wish to continue:** ❑ Medical/Dental ❑ Medical only ❑ Dental only Dependents of a retiree may choose medical/dental or medical only coverage.

❑ **Cancel all coverage** **Reason**_____ **Date of event** _____

**Are you covered by another group medical or dental plan?** ❑ Yes ❑ No Effective date_____

**Are you disabled under Title II (OASDI) of the Social Security Act?** ❑ Yes ❑ No Effective date_____

**Are you disabled under Title XVI (SSI) of the Social Security Act?** ❑ Yes ❑ No Effective date_____

**If yes**, **attach a copy** of your Social Security Disability Award letter.

**Are you enrolled in Part(s) A and/or B of Medicare?*** Part A (hospital) ❑ Yes ❑ No Effective date_____

Part B (medical) ❑ Yes ❑ No Effective date_____

***Note:** If you are enrolled in Medicare Part(s) A and/or B, **attach a copy** of your Medicare card(s) along with this form.

**C**

| Relationship to subscriber | Social security number | Physician or clinic code | ❑ Disabled? ❑ Student? *Check only if age 20 or older.* | Sex ❑ M ❑ F |
|---|---|---|---|---|
| | | | | |

| Last name | First name | Middle initial | Date of birth (mm/dd/yyyy) |
|---|---|---|---|
| | | | |

| Address (if different from subscriber) | City | State | ZIP Code |
|---|---|---|---|
| | | | |

**Select coverage you wish to continue:** ❑ Medical/Dental ❑ Medical only ❑ Dental only Dependents of a retiree may choose medical/dental or medical only coverage.

❑ **Cancel all coverage** **Reason**_____ **Date of event** _____

**Are you covered by another group medical or dental plan?** ❑ Yes ❑ No Effective date_____

**Are you disabled under Title II (OASDI) of the Social Security Act?** ❑ Yes ❑ No Effective date_____

**Are you disabled under Title XVI (SSI) of the Social Security Act?** ❑ Yes ❑ No Effective date_____

**If yes**, **attach a copy** of your Social Security Disability Award letter.

**Are you enrolled in Part(s) A and/or B of Medicare?*** Part A (hospital) ❑ Yes ❑ No Effective date_____

Part B (medical) ❑ Yes ❑ No Effective date_____

***Note:** If you are enrolled in Medicare Part(s) A and/or B, **attach a copy** of your Medicare card(s) along with this form.

## Section 3: MEDICAL PLAN SELECTION

*Check only one.*

- ❑ Community Health Plan Classic*
- ❑ Group Health Classic*
- ❑ Group Health Valuec.*
- ❑ Kaiser Permanente Classic
- ❑ Kaiser Permanente Value
- ❑ Regence Classic
- ❑ Uniform Medical Plan

**** These plans require the physician or clinic code of your selected primary care provider. You may find the code in the provider directory on our Web site or by calling the plan.***

## Section 4: DENTAL PLAN SELECTION

*Check only one.*

**Preferred Provider Organization**

❑ Uniform Dental Plan (Group #3000)
(may receive services *from any provider*)

**Managed Care Plans**

❑ DeltaCare (Group #3100)
Dentist name_____
(must receive services from *DeltaCare provider*)

❑ Regence BlueShield Columbia Dental Plan
Clinic location _____
(must receive services from *Willamette Dental Group provider*)

***Note:*** **Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.**

## Section 5: SIGNATURE *Required*

I/we have received and read this entire *Extension of Coverage Election Notice* including any appendices. I/we understand that insurance coverage is determined through verification of eligibility by PEBB Benefit Services. I declare that to the best of my knowledge and belief the individuals listed on this election form are eligible for the coverage requested. This form supersedes all forms and submissions I have previously made for coverage. A premium deposit does not guarantee coverage and will be returned if it is determined that individuals electing coverage are ineligible for coverage.

Washington State law may require disclosure of any information you submit as a public record. The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

Signature _____ Date_____

Relationship to individual(s) listed on form _____ Daytime phone number (_____)_____